S-41A

INCIDENT/INJURY REPORT FORM

REPORT ALL INJURIES WITHIN 24 HOURS

PLEASE TYPE OR PRINT IN BLACK INK. BE SURE TO PROVIDE ALL REQUESTED INFORMATION

I. EMPLOYEE REPORT:

DEPARTMENT/EMPLOYER:

LAST NAME: MIDDLE INITIAL: FIRST NAME:

ADDRESS: Street, #: City: State: Zip:

HOME PHONE: SOC SEC #: - - SEX: M F AGE:

JOB TITLE: DATE OF INCIDENT: TIME OF INCIDENT:_____AM/PM

BUILDING AND/OR AREA NORMALLY ASSIGNED:

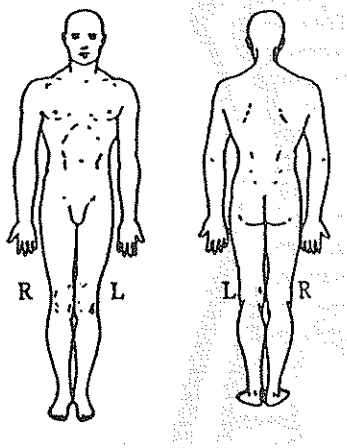
BUILDING AND/OR AREA WHERE INCIDENT OCCURRED:

HOW MANY HOURS HAD YOU BEEN WORKING IN A ROW WHEN THIS OCCURRED?

DO YOU HAVE SUPPLEMENTAL EMPLOYMENT? Y N

WHAT ARE YOUR NORMAL WORK HOURS?
_____AM/PM TO _____AM/PM

INDICATE ON THESE FIGURES THE AFFECTED BODY PART(S) AT TIME OF INJURY:



DESCRIBE AND ILLUSTRATE (AT LEFT) YOUR INJURY:_____

DESCRIBE THE INCIDENT: _____

WAS INJURY/INCIDENT REPORTED TO SUPERVISOR? YES NO

WAS INJURY/INCIDENT WITNESSED BY ANYONE? YES NO

WITNESS NAME (PRINT):

EMPLOYEE SIGNATURE: DATE:

WITNESS SIGNATURE: DATE:

II. SUPERVISOR REPORT :

DATA AND TIME NOTIFIED

WAS THERE A SPECIFIC INCIDENT/ACCIDENT? Y__N__UNKNOWN__ DID YOU WITNESS THE INCIDENT/ACCIDENT? Y__N__
GIVE A STEP BY STEP DESCRIPTION OF WHAT YOU UNDERSTAND TO HAVE HAPPENED:

WAS EMPLOYEE SENT TO DESIGNATED HEALTH CARE FACILITY FOR EVALUATION Yes____ NO____

1.____BODILY MOTION	2.____INMATE/PRISONER HANDLING	3.____OBJECT HANDLING	4.____CONTACT
5.____SLIP/FALL	6.____EXPOSURE/INHALATION	7.____INMATE/PRISONER ASSAULT	8.____CAUGHT
9.____COLLISION/UPSET	10.____AGGRAVATION OF PRE-EXISTING CONDITION		11.____MISCELLANEOUS

SUPERVISOR NAME (PRINT): SIGNATURE: DATE:

ADMINISTRATOR'S SIGNATURE: DATE: